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ADMINISTRATION MSA EXPANSIONS COULD DRIVE UP HEALTH INSURANCE PREMIUMS AND CREATE NEW TAX SHELTER

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Summary

Few would propose yet another tax cut targeted towards the affluent that also increases health insurance premiums for the sick. That is the probable consequence, however, of the Administration's budget proposal to expand Medical Savings Accounts (MSAs).[1] Representative Bill Thomas has introduced a nearly identical bill.[2]

The Administration proposal would dramatically expand an MSA demonstration project that Congress established in 1996 and that is scheduled to end in 2002.[3] In general, the proposal would make the demonstration permanent, permit universal access to MSAs, make MSAs more attractive by lowering deductibles that qualify an insurance policy for use with an MSA, and remove a number of safeguards included in the demonstration project that deter use of MSAs as a tax shelter for high-income taxpayers.[4]

- The Administration proposal would make the accounts universally available. Currently, usage is limited to people who work for small employers or who are uninsured. If MSAs become widely popular among consumers with relatively better health, which may be encouraged by wider availability and lower policy deductibles, an adverse selection cycle could be triggered that would drive up the cost of conventional, more comprehensive low-deductible insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans.

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[1] Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the MSA-holder's insurance policy.

[2] H.R. 1524 (introduced April 4, 2001). Many of the provisions included in both initiatives were included in a proposal by Representative Bill Archer last year and in the House-passed version of the Patients' Bill of Rights in 1999 (H.R. 2990).

[3] The MSA demonstration was originally scheduled to sunset in 2000 but the Community Renewal Tax Relief Act of 2000 extended the program until 2002. It also renamed the demonstration as the "Archer MSA" program.

[4] U.S. Department of Treasury, *General Explanations of the Administration's Fiscal Year 2002 Tax Relief Proposals*, April, 2001.

- Evidence suggests adverse selection in the usage of MSAs already is occurring under the demonstration project. A survey of insurers offering MSA plans notes that "Insurers expect relatively better health status and lower service utilization by enrollees selecting high-deductible plans and *price their products accordingly*." [Emphasis added.] In other words, the insurers can afford to set lower premiums for insurance policies used with MSAs, because they know that MSAs attract healthier people. This survey of insurers was conducted by Westat under contract with the General Accounting Office in partial fulfilment of the terms of the demonstration project Congress established in 1996. Universal eligibility and lower "high" deductibles would greatly exacerbate the trend to adverse selection.

In addition, the changes in the Administration proposal could create a major new tax shelter. The tax shelter would come about because of the similarities between MSAs and Individual Retirement Accounts. Under current law, married taxpayers who are covered by an employer-sponsored pension plan may deduct from their income up to $4,000 a year for deposits to an IRA if their income is below $63,000. By 2007, they will be able to make such deposits if their income is below $100,000.[5] Earnings on funds deposited in an IRA compound free of tax; no tax is due on either the deposits or the earnings until funds are withdrawn after retirement (or for a limited number of other purposes).

Taxpayers with incomes above these limits who have pension coverage under employer-sponsored plans are not eligible to use deductible IRAs. When IRA policies were revised in 1986 and again in 1997, Congress determined that such income limits were appropriate largely because evidence indicates that higher-income individuals can and will save without a taxpayer subsidy; giving high-income taxpayers a tax subsidy for saving is not an efficient use of government funds.

Nevertheless, MSAs could be used by high-income taxpayers as a means to circumvent the income limits that currently govern tax-advantaged deposits to Individual Retirement Accounts. Under the proposed MSA expansion, anyone may participate in MSAs and may make deductible contributions equal to 100 percent of the health insurance high deductible (current law permits only 65 percent for individual taxpayers and 75 percent for married taxpayers). As a result, *all* high-income taxpayers who choose to use MSAs would be allowed to make tax deductible deposits up to $2,350 for individuals and $4,650 for couples (the maximum high deductibles permitted), and the earnings on these MSA deposits would compound free of tax. Like funds deposited in an IRA, funds on deposit in an MSA may be invested in stocks, bonds, or similar types of assets. MSA deposits and earnings are never taxed if MSA funds are used to pay medical costs. Moreover, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-

[5] Single taxpayers with incomes below $43,000 may deduct up to $2,000 a year. These income limits apply for tax year 2001; the limits are increasing gradually though 2007 under legislation enacted in 1997.

medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits over a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

The original intent of the MSA program was to determine whether encouraging the use of health insurance policies with high deductibles would deter unnecessary utilization of health care services, which could contain rising health care costs. Yet, the Administration proposes lowering the minimum health insurance high deductible to $1,000 for individuals and $2,000 for families (down from $1,550 and $3,100 respectively). By reducing the minimum high deductibles, MSA insurance policies become more similar to traditional coverage, thereby making these products more attractive to high income taxpayers and encouraging their use while lessening their theoretical ability to deter health costs.[6] As a result, a supposed demonstration in testing the cost-effectiveness of MSAs is transformed into nothing more than a smokescreen for yet another tax cut for those with high incomes.

The Westat survey of MSA insurers indicates that the MSA market is already developing in this manner.

- According to the Westat survey, "Insurers reported targeting some segments of the insurance market, including highly-paid professionals, farmers and ranchers, partnership firms, and association groups."

- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses."

- Universal availability of MSAs, along with other changes in the proposal such as larger allowable deposits into MSAs and more attractive high deductible policies, would likely accelerate this trend.

The Administration proposal also includes a provision addressing employer and employee contributions to MSAs. This provision would undermine the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

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[6] In fact, the Thomas bill would permit MSA health insurance plans to require no deductible for preventive services (conventional insurance often has this feature). The provision in the Thomas bill is intended to encourage the participation of traditional PPOs in MSA high deductible plans. Current law permits MSA plans to require no deductibles for preventive services only if state law prohibits such deductibles.

- Under the MSA demonstration now underway, deposits can be made to an MSA account by either an employer or an individual, but not by both in the same year. The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.

- The Administration proposal would allow both employees and employers to make deposits to an MSA in the same year, so long as the aggregate contributions do not exceed the cost of the deductible. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income. Most lower-paid staff would not be able to afford substantial additional contributions and, because they generally are in lower tax brackets than better-paid employees, would get less subsidy for making their own deposits.

The Medical Savings Account expansions proposed by the Administration represent a dramatic departure from the current design of MSAs that would likely have adverse consequences for health care consumers. They carry the strong potential to drive up the cost of comprehensive, conventional insurance to the point where many Americans, including those most in need of health services, cannot afford to buy coverage. Moreover, the expansions would significantly increase the appeal of MSAs as a tax shelter for higher-income individuals, facilitating their greater participation in MSAs and further compounding the risk of triggering adverse selection in the conventional health insurance marketplace.

The MSA Demonstration

The bipartisan Health Insurance Portability and Accountability Act of 1996 established a demonstration to test and evaluate Medical Savings Accounts, which are tax-advantaged personal savings accounts that may be used by persons covered by health insurance policies with high deductibles.[7] The demonstration was designed to provide information about the effects of MSAs on workers, employers, and insurers and to do so without creating widespread, irreparable harm to the participants or the insurance market as a whole. Participation in the demonstration was limited to no more than 750,000 participants who are either employees of small businesses (businesses with 50 or fewer employees) or self-employed individuals. Participants could deduct contributions to their MSAs up to 75 percent of the health insurance deductible for couples (65 percent for individuals). Other rules governing use of MSAs during the demonstration were designed to assure that these tax-advantaged savings accounts were used largely for the purpose of obtaining medical care and would not become a general-purpose tax shelter. The

[7] In 2001, high deductible plans must have deductibles not less than $1,550 and not more than $2,350 for individual coverage and not less than $3,100 and not more than $4,650 for family coverage.

demonstration was originally scheduled to run through 2000 but was extended last year to December 31, 2002.

HIPAA required an evaluation by GAO to determine the effects of MSAs on the insurance market and on consumers. Among other issues, the evaluation was to study the extent to which MSAs fostered "adverse selection" — a situation in which younger and healthier individuals find MSAs financially advantageous and choose MSAs while older and less healthy individuals remain in conventional insurance. The evaluation also was to study the effect of MSAs on health care costs, including any impact on the premiums of individuals with comprehensive coverage. The intention was that Congress would be able to examine the results of the evaluation and, on the basis of those results, determine future policy regarding MSAs.

Few consumers, however, have chosen to use MSA during the demonstration period; in the taxable year 1998, the last year for which IRS data is available, only 42,477 tax returns included MSA contributions. IRS estimated that an additional 11,727 taxpayers used MSAs in 1999.[8] As a result of the low utilization, a full GAO evaluation of the effects of MSAs could never be conducted. One portion of the evaluation was completed — a survey of insurers, which was conducted by Westat under contract to GAO.

MSA proponents attribute the lack of popularity of MSAs during the demonstration period in part to various safeguards included in the demonstration legislation that were intended to prevent abuse of the accounts. Almost as soon as the demonstration was put in place, bills were introduced in Congress to relax the safeguards.

Another possible interpretation of the sparse usage of MSAs during the demonstration project is that MSAs are not attractive as a health insurance product per se and can gain acceptance only if MSA policies allow substantial abuse of the accounts as tax shelters. The Administration proposal would remove many of the anti-abuse protections while also making MSAs universally available and lowering the minimum high deductibles to make the health insurance products more attractive.

MSAs and Adverse Selection

A major concern is that universal access to MSAs would trigger widespread adverse selection in the insurance market. Adverse selection in the health insurance market takes place when healthy and less healthy segments of the population become segregated in different types of insurance plans. If healthier people choose high-deductible insurance with MSAs, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher-than-average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise. MSAs pose a strong risk of engendering this type of effect.

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[8] IRS Announcement 99-95 (October 1, 1999).

Young, healthy people who anticipate having low health care costs in the near future would likely choose to participate in MSA plans. They would do so because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. Thus, people with low health care costs can accumulate tax free earnings on those funds and use them as retirement savings or for other purposes.

On the other hand, older and less healthy people who judge they are likely to incur significant health care costs would be better off financially if they remained covered by conventional health insurance, which generally has lower deductible amounts and relatively low caps on out-of-pocket expenditures. As a result, the pool of workers who will retain conventional insurance if MSA use becomes widespread could incur much-higher average health care costs than the larger pool of workers who are covered by conventional insurance today. To accommodate those higher average health care costs, the premiums charged for conventional insurance policies would have to increase, perhaps dramatically.

Research suggests that the premiums for coverage under a conventional health insurance policy could nearly double or even increase as much a four-fold, depending on the degree of adverse selection that MSAs trigger in the insurance market.[9] At those increased premium rates, it is likely that significant numbers of employers would be unwilling to offer their employees conventional insurance and also that the resulting decline in the market for conventional insurance would lead some insurers to cease selling it.

Administration MSA Provisions

The Administration proposal would make the MSA demonstration permanent, open up MSAs to use by all individuals and employees, remove the numerical cap on participation and lower the minimum high deductibles.

- Universal availability for MSAs and more attractive health insurance products would mean that any negative consequences that MSAs may have for the insurance market could become pervasive and difficult to reverse.

- The available evidence from the survey of insurers conducted under the demonstration project suggests that insurance companies set premiums for MSAs based on the assumption that adverse selection will take place. According to the report, "Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans....*Insurers expect relatively better health status and lower service utilization by enrollees selecting high*

[9] Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" Journal of the American Medical Association, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

deductible plans and price their products accordingly. Insurers confirmed this conclusion in the survey."[10] [Emphasis added.]

The proposal also would increase the maximum amount allowed to be deposited each year in the tax-advantaged Medical Savings Accounts to 100 percent of the health insurance high deductible. The current demonstration project places strict limitations on such deposits to prevent use of MSAs as general-purpose tax shelters.[11]

- MSAs are similar to conventional Individual Retirement Accounts: contributions are deductible from income, and tax is deferred on the amounts the accounts earn. While deposits and earnings are never taxed if MSA funds are used to pay medical costs, the tax advantages of MSAs can be substantial even if the funds in the accounts are later withdrawn and used primarily or exclusively for *non*-medical purposes. If deposits are held until retirement age, for example, there is no penalty for withdrawal for non-medical purposes. Even if funds are withdrawn for non-medical purposes before retirement age, there are a number of circumstances under which the value of the tax-free compounding of the deposits for a number of years would outweigh the penalty that must be paid for a non-medical withdrawal.

- MSAs differ from IRAs in one key respect — there are no income eligibility limits on MSAs that prevent wealthy people from using them as tax shelters. As a result, opening up MSAs to all individuals and increasing the tax-deductibles contributions that may be deposited into them, as the proposal would do, would enable high-income taxpayers who cannot use IRAs because of the income limits to begin using MSAs as significant tax shelters.

- The basis for the MSA demonstration was to test MSAs' cost effectiveness in discouraging the use of unnecessary health care services through a very high deductible of at least $3,100 for families ($1,550 for individuals). Yet by lowering the minimum deductible significantly (or waiving a high deductible for preventive services as does the Thomas bill), the Administration proposal makes MSA insurance products more similar to conventional insurance — suggesting that the purpose of deterring unnecessary health care expenditures is no longer a primary justification for MSAs. Moreover, the changes allow high-income taxpayers to take advantage of the tax shelter aspects of MSAs without sacrificing much in health insurance coverage.

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[10] U.S. General Accounting Office, *Medical Savings Accounts: Results From Surveys of Insurers,* December 31, 1998, GAO/HEHS-99-34, Appendix, p.14.

[11] As noted above, for individuals, the maximum amount that can be contributed annually under current law is 65 percent of the health insurance policy's deductible amount; for family coverage, it is 75 percent of the deductible amount.

- When the MSA demonstration was established, a number of financial experts pointed out the possibilities for use of the accounts as tax shelters for those with high incomes. An Associated Press article cited Eclipse MediSave America Corp., an MSA servicing company, as having calculated that "a family making $3,375 annual MSA contributions (the maximum allowed under federal guidelines), and earning 8 percent interest a year could accumulate $1.4 million in the account over 45 years. Even if they withdrew $1,000 a year, they still would accumulate $991,000."[12] The family would have accumulated these amounts tax-free. A *New York Times* article at that time included an example of a relatively well-off MSA holder who chose to pay medical expenses with other funds, leaving his MSA deposits to grow tax-free.[13]

- The Westat Report indicates the MSA market may indeed be developing in this way. According to the survey, "Insurers reported targeting some segments of the insurance market [for MSAs], including highly-paid professionals, farmers and ranchers, partnership firms, and association groups."

- In discussing changes in the ways MSAs were marketed between 1997 and 1998, the Westat report noted: "The entry of Merrill Lynch and other investment firms into the MSA trustee arena and the maturing of the market have led to increased investment choices for MSA holders. This trend may be affected as well by some insurers' perceptions that MSA enrollees are using their accounts primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for paying medical expenses."[14]

- If MSAs become universally available, the investment advantages of the accounts to higher-income taxpayers are likely to be widely marketed by banks and investment houses, much as IRAs are advertised. Advertising is far less feasible under current law, with only small businesses and the uninsured eligible to use the accounts. Advertising could both promote use of MSAs as tax shelters and could make healthier persons more aware of the possibility of using an MSA, thus promoting further adverse selection.

Finally, the Administration proposal includes changes that would circumvent the rules under the current MSA demonstration that prevent employers from setting up MSAs in a manner that primarily benefits highly paid executives and effectively discriminates against lower-paid employees.

- Under the MSA demonstration now underway, deposits can be made in an MSA account either by an employer or an individual, but not both in the same year.

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[12] Associated Press release by Vivian Marino, August 15, 1997.

[13] Margaret O. Kirk, "Medical Accounts: Mixed Reviews," *The New York Times*, July 5, 1998.

[14] U.S. General Accounting Office, *Medical Savings Accounts: Results From Surveys of Insurers*, December 31, 1998, GAO/HEHS-99-34, Appendix, pp. 15-16.

The demonstration also includes nondiscrimination rules requiring employers to make comparable contributions for all participating employees.

- The proposal would allow both employees and employers to make deposits in an MSA in the same year. That would make the nondiscrimination rules meaningless. An employer could make small, token deposits to the MSA accounts of all employees. Higher-income employees could add substantial additional funds to their accounts and exclude these additional amounts from their taxable income, but most lower-paid staff would not be able to afford substantial additional contributions.

The Administration proposal would greatly increase the potential for abuse of MSAs and use of the accounts as a tax shelter. These changes would make MSAs substantially more attractive and lead to much more widespread use by healthy, wealthy individuals. As a result, these expansions greatly compound the risk that MSAs pose to health care consumers, particularly those in need of comprehensive, affordable health coverage.